Rebalancing Workgroup MFP and BIP
April 5, 2016
12-2 PM
DHMH, Room L-3

Introductions: In- Person & Phone

Balancing Incentive Program (BIP) Updates

I. Maryland Access Point Updates

1. FFP time study ending and information being gathered. Next year, ACL is providing a small grant for No Wrong Door system for Assistive Technology. Each state received a survey to complete for CMS. Teja Rau has been gathering information from all areas and compiling results for CMS to represent Maryland.
2. Certified Person-Centered Planning will continue through the next year. Can become a Certified Trainer and provide the training. Emily Miller (MDoA) continues to provide the training.
3. Working with DDA on training program and curriculum, though person-centered planning approach.

II. Assessment Updates

1. DLA-20
   a. Conference call on March 21 with DHMH, BHA and MTM to discuss training goals and expectations. Annie Jenson will provide the training.
   b. Clinicians and unlicensed professionals working with mobile treatment, PRP and the ACT (Assertive Community Team) will be implementing the DLA-20.
   c. DLA-20 will need to be configured into the authorization system through the ASO so providers can enter online. In the mean time, it will be completed on paper and manually entered.
   d. Prior to the training, a webinar will be sent to all participants explaining the tool, why it is used, implementation and expectations of the training.
   e. In person training to be held on 3 consecutive days. Over the first 2 days, 200 providers will be trained to implement the DLA-20. On the 3rd day, of those 200 providers, 40 people from BHA, University of MD and the ASO will attend the train the trainer session. BHA still determining what providers will be trained and who will be the Certified Trainers.
   f. For the trainers: A month after the initial training, a webinar will be held to discuss concerns, answer questions and go over "homework" assignments. Two months following, the final webinar will be held to discuss how to train staff, create webinars and support the implementation.
   g. Steven Reeder will oversee the training and explore "booster" plan for ongoing training/re-training, updates and verification of reliability and validity. MTM can provide ongoing trainings, provide webinars and assist in data evaluation.
   h. Training date, to be determined.

2. MPAI-4 Update
    a. Training and implementation of the MPAI-4 was held at BHA in December. All providers present.
    b. Currently all providers are using the assessment for person-centered care planning to determine needs and goals.
    c. Completed on paper copy at this time and this summer, a BHA intern will be manually entering the data for tracking baseline data and progress over time.
    d. No current concerns or issues reported at this time. Meeting to be held with providers on April 19 to get feedback.
    e. All paper copies and care planning information is uploaded in LTSS under attachments until the MPAI-4 is configured in the LTSS system.

3. InterRAI Training
    a. Currently the interRAI training is being held in different regions. Required to take test at end of training to show competence completing this assessment. This meets BIP requirements.

III. Level One Screen
    a. Hilltop assessed 4,393 Screens performed by MAP staff over past 15 months. (As of 4/5/16, 5,118 have been completed)
    b. Assessed individuals that were initially in the community and had a subsequent nursing facility stay, also reviewed interRAI and MDS data
    c. Two potentially valuable questions were not on the screen so they were added on 3/19:
        i. In general, how would you rate your health? (Self report only)
        ii. Time since last hospital stay (within last 90 days)
    d. We will do research with the additional questions to refine the algorithm so for the time being we have removed the score from the results page of the screen
    e. MFP staff are working to consolidate duplicate records in the tracking system that resulted when the registry was imported, hope to have this completed shortly so we can import the final individuals added to the registry and start the Schaefer Center work.
    f. Teja Rau recommended that MDoA provide assistance, suggestions or guidance for Level 1 Screening completion.

Money Follows the Person (MFP) Updates

IV. Housing Updates
1. DHMH Activities
    a. Rebecca Raggio and Maxine Arena provided housing program information and updates to Anne Arundel AAA and MMARS at staff meetings.
        i. SPAs interested in scheduling presentations on the affordable housing initiatives in Maryland or Housing 101 training can contact Rebecca at rebecca.raggio@maryland.gov or call 410-767-4948 to schedule training.

b. Rebecca will be hosting a webinar for Coordinators for Community Services on the affordable housing initiatives on April 25, 2016 at 10:00 am. Information is available on DDA's training calendar. Will most likely be hosting these webinars quarterly to give updates on eligibility, any changes or discuss available resources.

2. Maryland Partnership for Affordable Housing (MPAH)
    a. The Advisory Group (made up of representatives from DHMH, DHCD, MDOD, DDA, BHA, and the CIL network) continues to meet regularly to discuss development and implementation of housing programs such as Weinberg Units, 811 PRA, and MFP Bridge.
    b. The Case Management Subcommittee continues to have monthly calls and quarterly in-person meetings.
        i. Monthly calls are held with case managers assisting individuals who are applying for upcoming Section 811 properties to provide program information and technical assistance on the application through move in process and for case managers supporting current 811 tenants with sustaining successful tenancy.
        ii. Quarterly in-person meetings are open to representatives from cross-disability case management agencies and will provide general information and updates on MPAH's housing programs. The next meeting is scheduled for April 7 at 1:30 p.m. at 7000 Tudsbury Rd, Windsor Mill MD 21244.
3. HUD Section 811 Project Rental Assistance Demonstration
    a. Maryland received two funding awards from HUD for Section 811 Project Rental Assistance Demonstration to provide project-based rental assistance to people with disabilities who are low-income, Medicaid recipients between the ages of 18 and 61.
        i. The first grant was awarded February 2013 to provide rental assistance to 150 units in the Baltimore and Washington, D.C. Metropolitan Statistical Areas
        ii. Identified projects:
            1. Harford County (Riverwoods at Tollgate- 13 units)- Leased
            The grand opening ceremony for Riverwoods at Tollgate is April 29, 2016 at 10:00 am.
            2. Anne Arundel County (Berger Square- 8 units) Under construction, applicants are being referred now
            3. Baltimore County (Red Run Station- 11 units)
            4. Frederick City (Sinclair Way- 11 units) Closed 12/22/15, referrals will begin June 2016
            5. Montgomery County (Woodfield Commons- 13 units)
            6. Prince George's County (Bladensburg Commons- 15 units) Closed 11/24/15, referrals will begin June 2016
            7. Prince George's County (Brinkley Hill- 5 units)- Closed 12/18/15, referrals will begin June 2016
        iii. The second grant was awarded March 2014 and will fund another 150 units statewide.
            1. The Cooperative Agreement was signed October 28, 2015

4. Affirmatively Furthering Fair Housing Marketing Plan
    a. HUD requires 811 PRA grantees to Affirmatively Further Fair Housing (AFFH) in accordance with AFFH Marketing Plans prepared by the grantees and approved by HUD.
    b. Maryland has determined that those least likely to apply for the Section 811 PRA Demo program are otherwise eligible persons with disabilities who have:
        1. Visual impairments
        2. Limited English proficiency
        3. Disabilities that impact their ability to communicate
    c. Rebecca is training supports planners during SPA visits on their AFFH responsibilities to assist with program outreach and referral to those least likely to apply
    d. Brochures about the program are available in Spanish, Russian, Farsi, Chinese, Vietnamese, and Korean. Please contact Rebecca Raggio, to request brochures in alternate languages – rebecca.raggio@maryland.gov; 410-767-4948
    e. MDOD has a staff person who will be providing outreach for persons residing in nursing facilities who are least likely to apply. Contact Nathan P. Bradley, CFC Program Manager, NathanP.bradley@maryland.gov or 410-767-3713 with referrals.
    f. MFP staff: Wayne Reed and Grace Serio have been providing AFFH outreach on Section 811 PRA to individuals identified as least likely to apply living at Potomac Center and Holly Center.
5. MFP Bridge Subsidy
    a. The MFP Bridge Subsidy registry opened on March 17, 2016. Individual's need to get on list now/as soon as possible.
    b. MFP Bridge Subsidy will only be available for MFP-eligible individuals transitioning from nursing facilities or state residential centers, and individuals in the Brain Injury Waiver that are transitioning from an ALU to independent renting.
    c. MFP Bridge Subsidy will be offered throughout Maryland for MFP eligible individuals ages 18 and up with a maximum household income of $15,000.
    d. The Bridge Subsidy will be tenant-based, similar to the Housing Choice Voucher (HCV) program. The Bridge Subsidy will provide rental assistance for up to 3 years. Individuals will transition to HCVs after that period with the exception of Montgomery County, which will offer project-based units. The program is projected to assist 87 individuals.
    e. Applicants selected for the program will locate a unit that suits their needs and has rent within the program guidelines.
    f. Individuals will pay 30% of their income for rent and utilities.
    g. MPAH hosted two MFP Bridge Subsidy trainings on March 9 and 10, 2016 for Supports Planners.
    h. There will be a gradual rollout of the MFP Bridge Subsidy program. The proposed schedule is as follows and is subject to change:
        i. Carroll County (5 commitments), Prince George's County (5 commitments), DHCD (18 commitments, Western MD and Eastern Shore)

ii. Anne Arundel County (7 commitments) and Baltimore City (15 commitments)
iii. Hagerstown (5 commitments), Easton (5 commitments), Baltimore County (10 commitments)
iv. Montgomery (10 public housing units), Harford (5 commitments), Howard County (5 commitments), St. Mary's County (5 commitments)

6. Other Housing Reminders
   a. Staff need user name and password for Social Serve
   b. Staff need to update information in Social Serve when contact information changes (applies to both staff and applicant information)
   c. Be responsive to the wait list manager: Christina Bolyard at the Maryland Department of Disabilities (MDOD)
   d. Rebecca Raggio, MFP Housing Director is going out upon request to SPAs to meet with them. If you would like Rebecca to come out and provide housing information, please contact her at rebecca.raggio@maryland.gov or call 410-767-4948.

V. MFP Budget
   a. We received notice of a no cost extension to give CMS additional time to review our budget request, no additional updates at this time.

VI. Transition Projections
   a. Chart of 1st quarter transitions through the years.
   b. Reviewed transitions from 2013 to current (Jan-March). 2016 is currently low, as reflected by the current information; however, the expectation is that the numbers will increase.

VII. Rebalancing Priority Survey Results-Small Group Activity
   a. Discussion points:
      i. Summary for each recommendation to include:
         1. Issue the recommendation addresses
         2. Who needs to be involved for the planning and implementation?
         3. What outcomes are we trying to achieve?
         4. How do we measure the outcomes?
         5. Factors to consider when determining pilot regions
      ii. Things to keep in mind:
         1. Some of these items may require procurement so don't be so specific as to limit competition or provide unfair input into the recommendations
         2. Do not make recommendations such as "give money for X Agency to provide the training"
         3. Since we are nearing the end of the demonstration, keep in mind the time frame it will take to start up the activity. If it takes too long, we won't have much data upon which to make a recommendation to continue the activity once MFP ends

4. Activities are subject to the operational protocol amendment process and must be approved by CMS

Small Group Activity Discussion & Ideas

Small Group and Discussions: MFP needs to know what stakeholders expect and how they see the roll out of the following services and programs. Please take into consideration procurement, vendors, how long it will take to implement since MFP is time limited. Due to State procurement processes, no recommendations will be considered for one specific provider to receive money to provide a specific task.

1. The use of PASRR and a Geriatric Behavioral Health Specialist(s) (GBHS) pilot
    a. The goal would be to pilot a position(s), Geriatric Behavioral Health Specialist(s), who would receive a referral for an individual who had a positive Level II screen at admission and is preparing for discharge. The Specialist would be included as part of the multidisciplinary discharge team to bridge the gap between nursing facility services to community. Ideally, each region would have an assigned GBHS who is familiar with the providers and local resources.
    b. Approaching discharge, the GBHS will complete PASRR Level II screening at discharge to assist individual in making a plan for the community that supports the needs of the individual. GBHS can also assist in making referrals to community specialist, provide resources to the individual/family and empower the individual to commit to the plan for a successful transition from long-term care to community.
    c. Issues that PASRR and a GBHS address
        i. Currently, if a person has a positive PASRR while in the nursing facility, there is no follow up upon discharge. The GBHS will provide assistance, resources and support with planning, while the individual is residing in the nursing facility and the community.
        ii. The GBHS will help in identifying mental health or substance abuse related needs specific to the individual who will provide ongoing follow up, monitoring and continue to be a link to community programs and resources.
        iii. Currently, it may be difficult to locate available services and resources, if even available, depending upon what region you reside. The GBHS will be able to provide resources for the geographic area contingent upon the individual's needs, goals and treatment plan.
        iv. Diversion before re-institutionalization. The GBHS can work with the individual & doctors/specialists on healthy/safe return to community and provide support & resources to the family and caregivers. The GBHS can provide additional follow-up with the individual and caregivers once transitioned back home.
    d. Involvement for planning and implementation
        i. Maryland Medicaid, Department of Health and Mental Hygiene
        ii. Behavioral Health Administration
        iii. Geriatric Behavioral Health Specialist(s)

iv. Local Health Departments
v. MAP sites/AAA
vi. Hospitals & Nursing Facilities
vii. Psychiatric nurse or LCSW (if possible)

e. Measuring outcomes
    i. Individual and the GBHS will determine goals and create a plan to achieve. The GBHS will continue to provide follow up and monitoring of progress. During the first year (post discharge), the GBHS will visit more frequently to verify the individual is successfully following treatment plan. If individual expresses concern to the GBHS or there has been a decline in mental or physical functioning, the GBHS can intervene and get supports involved or assist in linking individual to community resources.
    ii. For Medicaid only, track the rate of hospital admissions.
    iii. Track the rate of re-admission to long-term care.
    iv. Use the DLA-20 to track functional progress over time.
    v. Monitor and track individual's progress living in the community and success in following treatment plan.
f. Potential pilot area and factors
    i. It is recommended that 2 regions be used in the pilot:
        1. Suburban area (more resources available including transportation)
        2. Rural setting (less resources and more barriers to accessing)
g. Other thoughts to consider
    i. Hospitals and nursing facilities need more education and information about PASRR, completing the screening tools appropriately and expectations of Maryland.
    ii. Need to determine if the GBHS will provide basic follow up, monitoring and resources or will the GBHS be required to be a clinician?
    iii. Instead of having the local health department complete the Level II PASRR screen, have a contracted clinical psych nurse complete the screening. This would reduce the time between completion of the Level I & Level II PASRR and individuals could be discharged from the hospital to be most appropriate setting to support health needs.
    iv. Specialized services need to be clearly defined so the nursing facility understands why these services need to be provided to the individual. Most nursing facilities, due to per diem rate, do not have specialist working within the facility and there are concerns as to who will pay for the services.
    v. Specialized services need to be enhanced in the nursing facilities to support individuals' needs, as identified by a positive PASRR.
    vi. Aging in place is an important consideration. DDA currently has resources and housing placement that exists for people aging with behavioral issues. The mental health community does not have the same available resources (as DDA) or housing options, in a behavioral health setting, which allows people to age in place. The behavioral health homes are structured to monitor and manage behaviors but not necessarily

support people who are aging who require more support or total assistance with basic ADLs/IADLs.

vii. More resources need to be developed for the mental health/substance abuse community. First, resources are needed for people who are already in the mental health system but are aging and their current services cannot support all the health care needs. Second, resources are needed for individuals who are residing in the community with mental health and/or substance abuse issues that are not involved with the mental health system who need resources and information about local programs.

viii. Resources need to be localized and in certain geographic areas, resources are very limited or there are barriers to accessing services (like transportation). It is recommended that, at the least, resources be organized by region. Although, the group agrees that it would be more beneficial & ideal to have resources organized by county.

2. Enhancing existing housing assistance/housing search curriculum
    a. Fair housing training
    b. Include housing features in LTSS for ongoing monitoring and updates.
        i. Add to monthly monitoring form
        ii. Availability to run reports to measure outcomes
    c. Hands on technical assistance from MFP housing staff to train Support Planners & AAAs on how to apply for housing and prepare the individual for the transition into independent renting.
    d. Factors to consider for pilot area
        i. Recommended pilot area: Baltimore City
        ii. What is the current affordable and accessible housing stock?
        iii. Information from the Public Housing Authority (PHA) to determine capacity of vouchers, programs offered public housing & project-based portfolio.

3. Expedited CFC enrollment for MA-eligible individuals discharging from hospital
    a. Expedited CFC enrollment will provide people with community MA, to discharge directly from the hospital back to their home with limited services until Support Planner can develop comprehensive plan of service.
    b. Involvement for planning and implementation
        i. MFP to provide marketing for home and community based services.
        ii. CFC staff from MA/DHMH
        iii. LHD/AERS nurse to expedite InterRAI evaluation to determine health needs.
        iv. A professional (from the hospital) will need to screen individual to determine if referral to the LHD/AERS should be made because this person should be in the community.
        v. A representative to screen individual's home to see if housing is safe/accessible or if housing unstable/safety concerns.
        vi. Support Planners who can explain in "plain language" CFC, person-centered planning, community supports and accessibility.

vii. Educators to train medical discharge planners on what community options are available, eligibility criteria and expectations of the discharge planner (for example: provide scripts/order any DME, DMS, skilled services and/or new medications prescribed).

c. Outcomes attempting to achieve
    i. Hospitals will need an indicator if patient is MA eligible.
    ii. Medicaid to attempt to replicate private insurance home assistance time frames.
    iii. Hospital staff to be more aware of available community options so the staff can improve on asking for supports at home and make appropriate referrals.
    iv. Process for medication reconciliation for ongoing monitoring. Immediately after discharge, individual to have more frequent nurse monitoring visits to provide oversight and monitor overall general health.
    v. Provide minimal services (for example: RN monitoring, attendant care services, home delivered meals), that can be accessed immediately upon discharge from hospital to community home.
    vi. Individuals/caregivers will recognize/identify health issues before hospital admission to get appropriate follow-up.
    vii. Encourage pilot program through "promise" of lower recidivism.
d. How to measure outcomes
    i. Evaluate data for CFC participants, who went through expedited process, re-hospitalization rates.
    ii. Review data that reflects date of expedited CFC enrollment with participant's current status. If participant is no longer enrolled in CFC, document reason and date of closure.
e. Factors to consider for pilot area
    i. Coordinate team to develop RFP to pilot program in a variety of health care settings.
    ii. Consider piloting in a rural location not an urban/large suburban area.
    iii. Pilot program in several hospitals and trauma centers.
        1. Select hospitals that will provide a reasonable sample of feasibility.
        2. Select hospital who can provide data that shows how many people were admitted from their community home to the hospital.
    iv. Recommended to pilot in rehabilitation hospitals like Kernan, Shady Grove or Adventist Hospital.
f. Other thoughts to consider
    i. Will the expedited process impede with the Freedom of Choice?
    ii. Who will complete a home evaluation to determine accessibility and safety needs?
    iii. Will the expedited CFC process support an individual with a new disability/diagnosis in need of environmental modifications?
    iv. Consider interim Support Planning units for expedited team.
    v. Consider re-evaluation/re-assessment time frames if services are expedited.

vi. The process and professional responsible for completing a home evaluation to determine if a person's home is accessible to health and safety needs.

4. In-home behavioral health treatment
    a. Provide support (in-person or trainings) for individuals identified of needing behavioral health treatment in their home for successful community living. Develop a plan of service to specifically address behavioral health needs.
        i. Services based on need/preferences and not ADL/IADL eligibility
        ii. Provide in-home drop in supports
    b. Involvement for planning and implementation
        i. BHA
        ii. Core Service Agencies
        iii. MFP
        iv. DDA
        v. Support Planning Agencies
        vi. ACT team
        vii. Peer Recovery Team
        viii. Attendant care provider agencies
        ix. Informal (unpaid) supports/family
    c. Outcomes attempting to achieve
        i. Person-Centered planning meeting would occur with the individual and supports to discuss needs (1-2 hour in depth meeting) and develop plan of service.
        ii. Better transition plans with a warm handoff.
        iii. Attendant care provider and supports to complete Mental Health First Aid.
        iv. Ongoing 1 on 1 mentoring (ACT team), as needed.
        v. Ongoing peer to peer support.
        vi. Anxiety reduction through different methods like relaxation techniques.
    d. How to measure outcomes
        i. Successful housing tenancy
            1. No lease violations
            2. Pays bills on time
            3. Participant reports generally happy
            4. Positive resident
        ii. Participant uses the services and resources to maintain overall health.
        iii. Self-reports from participant.
        iv. Reports/updates provided by members of the support team including the support planner, nurse monitor, attendant care provider, and family members.
    e. Factors to consider for pilot area
        i. All 811 and Weinberg Residents

5. Training Recommendations (no representation from meeting attendees)
    a. A lot of overlap with recommendations for training for SP's, direct care workers participants and family/informal support.

b. Recommendations for training (per survey responses)
    i. Understanding medical diagnoses and medication interactions
    ii. Falls prevention
    iii. Mental Health First Aid
    iv. Types of Dementia
    v. Basic infection control (already required by direct service workers)
    vi. Signs of hypo/hyperglycemia
    vii. Signs of infection

The next meeting is scheduled for ***Tuesday, June 7, 2016*** *from 12-2 in room L-3*